Global Commitment Appeals and Grievances

7110 Global Commitment Appeals and Grievances (08/01/2010, 10-01)

"Global Commitment" is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Department of Vermont Health Access (DVHA) is required under the Global Commitment to Health 1115(a) waiver, to implement all 42 CFR Part 438 regulations, related to Managed Care Organizations, in its operations. Under 42 C.F.R. Part 438, Subpart F, the Managed Care Entity is required to have an internal grievance and appeal process for resolving service disagreements between beneficiaries and the managed care entity, including employees, representatives, and state designated agencies, including Designated Agencies and Specialized Service Agencies.

The Managed Care Entity and any part of the entity receiving funds for the provision of services under Global Commitment shall be responsible for resolving all grievances and all appeals initiated under these rules.

Beneficiaries and providers shall not be subject to retribution or retaliation for filing a grievance or an appeal with the managed care entity.

Services funded with Managed Care Entity investments dollars are not Medicaid covered services, and are therefore not subject to grievance and appeal rules, except as otherwise provided for in rule (see annual DVHA Budget Document - http://DVHA.vermont.gov/budget-legislative). Beneficiaries retain their ability to file fair hearings with the Human Services Board for denials, limitations, reductions, suspensions or terminations of these services.

Note: Unless otherwise stated, all timeframes are stated in calendar days.

7110.1 Definitions (08/01/2010, 10-01)

The following definitions shall apply for use in rules 7110-7110.5:

A. "Action" means an occurrence of one or more of the following by the managed care entity for which an internal appeal may be requested:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;

2. reduction, suspension or termination of a previously authorized covered service or an approved (by the managed care entity) service plan;

3. denial, in whole or in part, of payment for a covered service;

4. failure to provide a clinically indicated, covered service, when the DA/SSA is acting as the managed care entity;

5. failure to act in a timely manner when required by state rule;

6. denial of a beneficiary's request to obtain covered services outside the network.

NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

NOTE: Collaborative decisions of any type made by multi-disciplinary groups that include managed care entity and non-entity members, such as Local Interagency Teams (LIT), the State Interagency Team (SIT), the State or Local Team for Functionally Impaired, and the Case Review Committee (CRC), are not actions of the managed care entity, see Medicaid Rule 7110.1(H), and therefore are not governed by Medicaid Rule 7110 et seq.

B. "Appeal" means a request for an internal review of an action by the MCO.

C. ""Designated Agency/Specialized Service Agency" (DA/SSA) means an agency designated by the Department of Mental Health (DMH) or Department of Disabilities, Aging and Independent Living (DAIL) to provide services and/or service authorizations for eligible individuals with mental health or developmental disabilities.

D. "Designated Representative" means an individual, either appointed by a beneficiary or authorized under State or other applicable law, to act on behalf of the beneficiary in obtaining a determination or in dealing with any of the levels of the appeal or grievance process. Unless otherwise stated in this rule, the designated representative has all of the rights and responsibilities of a beneficiary in obtaining a determination or in dealing with any of the levels of the appeals process.

E. "Expedited Appeal" means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

F. "Fair Hearing" means an external appeal that is filed with the Human Services Board, and whose procedures are specified in rules separate from the managed care entity grievance and appeal process.

G. "Grievance" means an expression of dissatisfaction about any matter that is not an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights.

If a grievance is not acted upon within the timeframes specified in rule, the beneficiary may ask for an appeal under the definition above of an action as being "failure to act in a timely manner when required by state rule."

If a grievance is composed of a clear report of alleged physical harm or potential harm, the managed care entity will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services).

H. "Managed Care Entity" means and includes:

1. the Department of Vermont Health Access (DVHA);

2. any State department with which DVHA has an Intergovernmental Agreement under Global Commitment, excluding the Department of Education, that results in that department administering or providing services under Global Commitment (i.e. Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; Department of Mental Health);

3. a DA/SSA; and

4. any contractor performing service authorizations or prior authorizations on behalf of the managed care entity.

I. "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

J. "Provider" means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individuals medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.

K. "Service" means a benefit 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Department of Vermont Health Access and Agency of Human Services Departments for the administration and operation of the Global Commitment to Health waiver.

7110.2 Beneficiary Appeals (08/01/2010, 10-01)

A. Right to Appeal

Beneficiaries may request an internal appeal of a managed care entity's action, and a fair hearing before the Human Services Board. A beneficiary may utilize the internal appeal process while a fair hearing is pending or before a fair hearing is requested (rule 7110.3), except when a benefit is denied, reduced, or eliminated as mandated by federal or state law or rule, in which case the beneficiary cannot use the appeal process and would challenge the decision only by requesting a fair hearing.

B. Request for Non-Covered Services

An appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA under the provisions of the Medicaid rules at 7104. A subsequent DVHA denial under rule 7104 to cover such service cannot be appealed using the appeal process set forth in this rule, but may be appealed through the fair hearing process.

C. Medicaid Eligibility and Premium Determinations

If a beneficiary files an appeal regarding eligibility for Medicaid or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (DCF), Economic Services Division. They will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the appeal process and will be considered a request for fair hearing as of the date the managed care entity received it.

D. Filing of Appeals

Beneficiaries may file appeals orally or in writing for any managed care action. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary's request. Appeals of actions must be filed with the managed care entity within 90 days of the date of the notice of action. The date of the appeal, if mailed, is the postmark date.

The appeal process will include assistance by staff members of the managed care entity, as needed, for the beneficiary to initiate and participate in the appeal.

E. Written Acknowledgement

Written acknowledgement of the appeal shall be mailed within 5 days of receipt by the part of the managed care entity that receives the appeal.

If a beneficiary files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the managed care entity, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part. This does not extend the deadline by which appeals must be determined.

F. Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the managed care entity in writing within 5 days.

G. Beneficiary Participation in Appeals

The beneficiary, their designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which the managed care entity is considering the final decision regarding their appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

Upon request, the managed care entity shall provide the beneficiary or their designated representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The entity will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

H. Appeals Reviewer

The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual that made the original decision. Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite clinical expertise, as determined by the managed care entity, in treating the beneficiary's condition or disease.

I. Resolution

Appeals shall be decided and written notice sent to the beneficiary within 45 days of receipt of the appeal. The beneficiary shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 45 day time limit, the time frame may be extended up to an additional 14 days, by request of the beneficiary or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the managed care entity, is 59 days. If a meeting cannot

be scheduled within these timeframes, a decision will be rendered by the managed care entity without a meeting with the beneficiary, their designated representative, or treating provider.

7110.2.1 Expedited Appeal Requests

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the managed care entity for any actions subject to appeal. The managed care entity will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

If the request for an expedited appeal is denied because it does not meet the criteria, the managed care entity will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited appeal must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice.

If the expedited appeal request meets the criteria for such appeals, it must be resolved within 3 working days. If an expedited appeal cannot be resolved within 3 working days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay. An oral notice of the expedited appeal decision must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the beneficiary's right to request a fair hearing if not already requested.

7110.2.2 Participating Provider Decisions

Provider decisions shall not be considered managed care entity actions and are not subject to appeal using this process.

A state agency shall be considered a provider if it provides a service that is:

A. Claimed at the Medicaid service matching rate;

B. Based on medical or clinical necessity; and

C. Not prior authorized.

Designated Agencies/Specialized Service Agencies (DA/SSA) are providers when their decisions do not affect beneficiary eligibility or services.

7110.2.3 Notices, Continued Services, and Beneficiary Liability

A. Beneficiary Notice

The part of the managed care entity issuing a services decision that meets the definition of an action must provide the beneficiary with written notice of its decision. In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least 11 days before the change will take effect. Where the decision is adverse to the beneficiary, the notice must inform the beneficiary:

1. what action is being taken;

2. the reason for the action

3. the specific rule that supports the action; and

4. explain when and how to file an appeal or fair hearing, and that he or she may request that covered services be continued without change as well as the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any appeal or fair hearing.

B. Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:

   a. The managed care entity appeal was filed in a timely manner, meaning before the effective date of the proposed action;

   b. The beneficiary has paid any required premiums in full;

   c. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and

   d. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.

2. Where properly requested, a service must be continued until any one of the following occurs:

   a. The beneficiary withdraws the appeal;

   b. Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;

   c. The managed care entity issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;

   d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or

   e. The time period or service limits of a previously authorized service has been met.

Beneficiaries may waive their right to receive continued benefits pending appeal.

C. Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law or rule affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at rule 4150).

D. Beneficiary Liability for Cost of Services

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

The managed care entity may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant managed care entity or fair hearing decision is made, or following a final disposition of the matter in favor of the managed care entity. Beneficiary liability will occur only if an appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the managed care entity also determines that the beneficiary should be held liable for service costs.

If the provider notifies the beneficiary that a service may not be covered by Medicaid, the beneficiary can agree to assume financial responsibility for the service. If the provider fails to inform the beneficiary that a service may not be covered by Medicaid, the beneficiary is not liable for payment. Benefits will be paid retroactively for beneficiaries who assume financial responsibility for a service and who are successful on such service coverage appeal.

E. Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the managed care entity is not required to initiate service delivery.

The managed care entity is not required to provide a new service or any service that is not a Medicaid covered service while a fair hearing determination is pending.

7110.3 Fair Hearing (08/01/2010, 10-01)

A beneficiary may utilize the managed care entity appeal process and be entitled to a fair hearing before the Human Services Board. Fair hearings or managed care entity appeals must be filed within 90 days of the date the notice of action was mailed by the managed care entity. A request for a fair hearing challenging a managed care entity appeal decision must be made within 90 days of the date the original notice of the managed care entity's decision being appealed was made, or within 30 days of the date the notice of the decision being appealed was mailed, whichever comes later. If the beneficiary's original request for an appeal was filed before the effective date of the adverse action and the beneficiary has paid in full any required premiums, the beneficiary's services will continue consistent with 7110.2.3 B.

Individuals have the right to file requests for fair hearings related to eligibility for Medicaid and premium determinations. DCF shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations.

7110.4 School-Based Health Services (08/01/2010, 10-01)

The State uses the School-Based Health Services Program to obtain Medicaid reimbursement for medical services provided by schools to eligible students. To be eligible, the students must be enrolled in Medicaid, receiving special education services, and receiving Medicaid-billable services. School districts can claim reimbursement under the Program only for those students on an individualized education program ("IEP") and not for students on 504 plans. A release of protected health information for each eligible student is required before any claims can be processed. The parent or guardian has the right to refuse to give consent to such a release. In such case, the school district cannot claim Medicaid reimbursement for any services provided to that student. Additionally, a physician or a nurse practitioner must sign a physician authorization form, establishing that the IEP services are medically necessary.

The federal Individuals with Disabilities Education and Improvement Act of 2004 (IDEIA) Part B has statutes and regulations that govern the process for assessing needs and developing the IEP. Separate Department of Education (DOE) due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child's identification, eligibility, evaluation, IEP or placement have three options available under the DOE procedures for resolving disputes with the school: mediation, a due process hearing and/or an administrative complaint. The Department of Education due process and appeals procedures also apply to Global Commitment services authorized under Part B of IDEIA.

IDEIA Part C is an Early Intervention program for infants and toddlers that provides a broad array of services to children with special needs, birth through three years of age, and their families. Services are authorized through the DCF - Child Development Division. Global Commitment services authorized under Part C of IDEIA are subject to the managed care grievance and appeal procedures.

7110.5 Beneficiary Grievances (08/01/2010, 10-01)

A. Filing Grievances

A grievance may be expressed orally or in writing. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

B. Written Acknowledgement

Written acknowledgement of the grievance must be mailed within 5 days of receipt by the managed care entity. The acknowledgement must be made by the part of the managed care entity responsible for the service area that is the subject of the grievance. If the entity decides the issue within the five day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.

C. Withdrawal of Grievances

Beneficiaries or their designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the managed care entity in writing within five calendar days.

D. Disposition

All grievances shall be addressed within 90 days of receipt. The decision maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with the managed care entity as well as information on how to initiate such review.

E. Grievance Reviews

1. Filing a Grievance Review - If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the managed care entity within 10days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

2. Written Acknowledgement - The managed care entity will acknowledge grievance review requests within 5 days of receipt.

3. Disposition - The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review within 90 days.

   Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the beneficiary may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V.S.A. §3091 (a).